II. NURSING HOMES AND THE LIABILITY INSURANCE MARKET

*The data available regarding nursing home liability insurance coverage are limited and generate more questions than they provide answers. Nursing homes are not required to carry liability insurance or to send information to DHS regarding liability insurance **claims** filed, premiums paid, or type of coverage held. It is not possible to predict statewide trends without complete information on the status of liability insurance premiums and claims in the State.*

DHS does have some data that indicate premiums are increasing and fewer companies are willing to write liability insurance policies for nursing homes. Available data indicates frequency and size of claims are also increasing.

"The long-term care industry has rapidly morphed itself to meet consumer demands, and underwriters who were pricing this business based on a real estate model are now pricing it on an acute care model."

–Ruth Kilduff, Senior Vice-President, Marsh USA Inc.

Skilled nursing facilities are both a type of housing unit and a provider of health care. In seeking insurance coverage, a nursing home will purchase a policy covering both **professional** and **general liability**. General liability insurance addresses the risk from accidents occurring on the property. Professional liability addresses the occurrences of "errors and omissions" on behalf of the employees, that the employer—the skilled nursing facility—could be held responsible for. Professional liability insurance is a form of **malpractice insurance.**

Historically, insurance companies regarded nursing homes as a low risk for liability claims; the residents had minimal income and the exposure to litigation was limited. Financial and business communities viewed nursing homes as "properties" since they are a type of living arrangement. Financial transactions were decided based on factors such as stock prices, capitalization rates, investment potential, occupancy rates, and profitability ratios.

At the same time, the population of a nursing home is typically over 75 years of age, and residents are very ill, very frail, and often disoriented. The residents are in a nursing home for the purpose of continuous access to skilled care. The focus on the quality of care provided by

these residences has shifted the business sector's view of skilled nursing facilities. Wall Street transactions for publicly traded nursing home chains have become highly reactive to policy changes by the **Center for Medicare and Medicaid Services (CMS)** and trends in residence rights actions.

THE PROCESS

There is neither a state nor federal requirement for skilled nursing facilities to carry liability insurance.

Skilled nursing facilities are not in a position that risk can be eliminated; however, a well-structured risk management plan is designed to assess where there is exposure to risk and respond appropriately. "Risk is anything that prevents an organization from accomplishing its mission. Risk is the possibility of suffering harm or loss. A factor, element or course involving uncertain danger or hazard, especially catastrophic events."[1]

As part of its **risk management** plan, the nursing home, like any other business, may purchase liability insurance to cover its legal liability that might result from injuries to residents, or others, or from damage to its property. Such a liability policy would pay for a claim that results from a court award or settlement. In the case of an accident, the insurance company may offer payment for medical bills or other expenses as "settlement" for the claim. A claim filed for a legal action would cover the case's applicable defense costs and awarded **damages**. Some policies will cover **punitive damages**, if awarded by the jury. The insurer pays the coverage amount, less the out-of-pocket deductible. Without such coverage, just one significant lawsuit could mean bankruptcy or closure.

A nursing home locates an insurance company to issue or write a liability policy. The facility might utilize a **broker** or marketing specialist to deal with either agents or companies in arranging for the coverage. An insurance company will ask a nursing home a variety of questions during the course of evaluating a potential insured. The answers to the questions will determine how the insurer **underwrites** the policy. The **underwriter** will decide whether or not the insurance company should accept the applicant, and what amounts or terms the insurance company will set for accepting the risk. During this process, the insurance company may evaluate the physical condition of the facility and grounds, safety procedures and safety devices, any claims filed against the facility, and management of residents' care. The insurance company may also evaluate the management structure for mitigating the exposure of risk. Ideally, risk management is in the form of a comprehensive, multi-faceted risk management program with continuous monitoring and review of risk exposure and opportunities for risk mitigation. Such a program will also include a committee structure designed to address the occurrences of an incident or the near occurrence, and include a communication and grievance procedure to address resident and family complaints or concerns.

Structure of the Insurance Policy

An insurance company writes a policy that, for a given premium, will cover: (1) a defined amount of claims—the maximum coverage—including a designated dollar amount for the maximum coverage allowable for each claim, and a total dollar amount of coverage for all claims payments; (2) a predetermined out-of-pocket responsibility of the insured for each claim—the deductible; (3) a specified period of time for the insurance coverage—policy term. The policy will also specify when the incident may occur, during the policy term, for the claim to be eligible for coverage. An **occurrence** policy covers claims arising out of occurrences that take place during the policy period, regardless of when the claim is filed. A **claims-made** policy only covers claims filed during the policy period. For example, if a patient falls in December 2001 and the SNF files a claim in February 2002, an occurrence policy written for calendar year 2001 would provide coverage for the claim. However, a claims-made policy—that is written for calendar year 2002—would not cover the 2001 claim. A claims-made policy can be less risky for the insurance company, and less costly for the SNF. The exposure to a claim is defined and limited; the insurance company's risk is reduced, and consequently it tends to carry a lower premium than an occurrence policy. But, a claims-made policy carries a greater level of risk for the SNF.

Nursing homes that cannot find a liability insurance carrier to write a policy for them, or cannot afford the premium amount, may choose to operate without liability insurance—known as "**going bare."** Many reports indicate that some nursing homes have announced that they are not insured for liability claims, in efforts to stave off frivolous lawsuits. Nevertheless, a facility that has "gone bare" faces the greatest financial risk, should a lawsuit be filed.

A claim against a liability insurance policy, by definition, implies that in some manner the action of the nursing home was inadequate for a given situation. This fact tends to be a source of tension between the insurer and the nursing homes in regards to how a claim should be handled. The insurers are motivated toward cost containment and predictability. A nursing home has their reputation and the reputations of their staff on the line for each one of these claims.

Currently, some SNFs are choosing to **self-insure**, insure with a large deductible, or go bare, for the purpose of gaining more control over the potential response to a claim or lawsuit. In this way, a facility will focus its risk management efforts towards mitigation of claims exposure and set the facility claims **reserves** or **loss reserve** based upon the facility's specific assessment of loss exposure. The facility might be more likely to challenge a claim in court if their assessment of the incident is that the facility is not at fault. The facility's motivation in claims disposition differs from that of an insurer. A facility that opts not to utilize a commercial insurer will ultimately determine the handling of an incident or a claim.

The fact remains that when losses do occur, organizations must pay for them somehow. Insurance is one of many methods available for financing losses. However, insurance does nothing to prevent a loss from occurring. The least costly accident in terms of safety, time, money and morale is the one that never happens.

Coverage Options

Numerous liability insurance options are available to a nursing home, depending on its circumstances. Basically, the choices are: traditional or **admitted policy**; excess or **surplus line** policy; **pooling arrangement**; and, self-insurance (see Table 2, page 9 and Table 3, page 24 for more detailed information).

Admitted Carriers

The first option for coverage is usually the admitted carrier, which covers the more traditional forms of insurance. From the perspective of the SNF, if the insurance company experiences financial distress, the regulatory agency—CDI—can intervene and provide protection. Admitted insurers are the only type of insurance or insurance carrier that CDI regulates. When a line of insurance becomes too risky or too cost prohibitive for traditional insurers to carry, alternative forms of insurance coverage will often be developed.

Alternative to the Admitted Insurer

If an insurance broker is unable to find coverage through an admitted insurer, or if the terms of the policy are unattractive, the broker can look to place the policy with an alternative underwriter, typically a surplus line. An array of pooling arrangements and self-funded insurance options also exist (see Table 3, page 24). A choice among these options would depend upon the availability of the products and the size of the organization. These options meet various state or federal standards and may or may not be regulated by a state department of insurance.

Reinsurers

Underlying all the insurance options is one consistent thread. The insurance carrier, insurance pool, or the self-insured entity, will go to a **reinsurer** to insure its risk exposure. The reinsurance industry is the “insurance company” for the insurance companies. The typical reinsurer is a multinational conglomerate that is unregulated by the state insurance agencies.

The reinsurer will review the insurance carrier’s underwriting and choose to “endorse” the policies and set a price (premium) for the exposure the reinsurer will assume. Reinsurers are analyzed by rating agencies and therefore have an incentive to show a fiscally strong operation with stability being the key criteria for a positive rating (see insert page 18).

TABLE 2.

Who are the insurers in the market?

Admitted Carrier

The "traditional" insurance company registered and regulated by the state insurance agency. From the perspective of the SNF, if the insurance company experiences financial distress, the regulatory agency—CDI—can intervene and provide protection. Policies are typically purchased through an insurance agent or broker. Currently, this market is experiencing large consolidations as fewer, bigger players are making up this segment of the business. This is a cyclical trend in the insurance industry, indicative of a **"hardening"** of the market or a more difficult competitive environment.

Excess and surplus lines companies

Non-admitted insurance companies.

As the insurance market is responding to more difficult competitive conditions, the standard insurers will retract their lines of business and focus on the core product lines. The "miscellaneous" lines of insurance then shift to the excess and surplus line companies. The migration of business into the surplus lines market is largely attributed to a reduction in capacity from the standard market and, to a lesser extent, increasing pressure from reinsurers. [τ]

As the market is shifting over to surplus lines of coverage, less rate data are available. Excess and surplus insurers are not regulated by the CDI.

Reinsurers

Reinsurers are the insurance companies for the insurance carriers. The reinsurer supports the primary insurers and assists the insurers in the ability to spread risk. The reinsurer will review the primary insurers' underwriting guidelines and choose to "endorse" the product lines. The reinsurer will establish a deductible, known as an **attachment point**, at which dollar level of losses the reinsurer will assume any additional liability. Or the reinsurer will take a group of policies, to write on a "**cessions**" basis where the insurer will cede risk for the group of policies, or "layer" of coverage, and pass the risk to the reinsurer. The reinsurer will collect a percentage of premiums for an endorsement or will collect the full premium for a cession.

The reinsurance industry is an unregulated entity. The reinsurers are analyzed by rating agencies, such as Standard & Poor's and A.M. Best. These organizations will rate admitted, excess, and surplus insurers, as well other insurance vehicles. (See insert, page 18).

[τ] David Pilla "Surplus Lines Thrive in Post-Sept. 11 Market," *BestWire Service*, A.M. Best's, January 28, 2002.

FACTORS LIMITING CHOICE FOR NURSING HOMES

Some facilities do not have many insurance options outside of paying the admitted insurer the asked premium. Bond covenants or loan agreements—the conditions that the borrower accepts as terms of their debt obligation—may require that the facility maintain liability insurance. Some debt relationships may even require that the carrier be considered A-rated by the insurance rating agencies. The insurance company also may be unwilling to provide coverage, or will limit the terms of coverage, because a facility has previously demonstrated poor performance or has had an insurance claims history.

Once a relationship is established with an insurance company, the insurer is a determining factor in how claims are handled. Often if a lawsuit is filed against the insured, the insurance company will pursue a settlement of the lawsuit or claim, in lieu of a trial or as a cap on the potential jury award. In this way, the insurance company limits the potential size of the claims. However, the SNFs may be concerned that they have not had the opportunity to challenge the lawsuit, since it reflects on the quality of care provided in the facility.

LIABILITY INSURANCE TREND

Admitted Insurers

It is difficult to gather measurable statistics to define the trend in the insurance marketplace. Admitted insurers are the only insurance carriers that CDI regulates. These are also the only entities that the CDI can compel to report premium data or, in other words, are under agreement to participate in agency "data calls." When an insurance segment is experiencing volatility, identifying trends and statistics becomes more difficult. Insurance coverage will start to shift among carriers as certain insurers withdraw from the marketplace and other forms of insurance become comparably more attractive.

Trend Data From CDI Data Call

40 percent average premium increase between 1999 and 2000.

In May 2001, the CDI conducted a data call to determine the state of long-term care liability insurance availability for nursing homes and assisted living facilities in California. A circular was mailed to the 448 companies licensed to write commercial multi-peril and other liability insurance coverage. Thirty-three companies responded noting any experience for the period of 1997 to 2001. Of those, only 21 licensed insurers indicated they were currently writing LTC liability insurance in 2001, four of which indicated that they offered renewal policies only. This meant that only 18 admitted insurers, representing 13 groups/companies, were accepting new business in 2001. Twelve other companies that responded had stopped writing during the five-year period. Reasons for discontinuing coverage included: profitability,

reinsurance, huge losses, and lack of underwriting expertise. Between 1999 and 2000, a 40 percent increase in the average premium per policy was reported. The average monthly premium per facility was $9,794.

FIGURE 1.

California Long-Term Care Liability Insurance
All Provider Types

Year	Number of groups/insurers (In parentheses are the number of insurers)	Written Premium	**Earned Premium**	Policies Earned	Number of Facilities Covered*	Average Premium per Policy ($)	Average Premium per Facility ($)	Claims Incurred	Incurred Losses	**Loss Ratio**
1997	14 (26)	9,833,448	8,220,369	1,746	2,083	4,707	3,946	310	17,780,746	216%
1998	14 (26)	9,334,387	10,255,534	1,880	1,947	5,455	5,267	409	21,358,800	211%
1999	18 (28)	11,742,554	11,352,628	1,535	1,503	7,396	7,553	409	19,959,021	176%
2000	17 (25)	7,669,954	8,266,068	801	844	10,320	9,794	261	8,843,103	107%
2001**	13 (21)	NA	NA	NA	NA	NA	NA	NA	NA	NA

* Unable to provide complete data for the number of facilities covered. Some insurers were unable to provide a complete count of number of facilities.
**2001 premium and loss information was not available at the time the study was conducted.

Source: California Department of Insurance.

CDI Skilled Nursing Facility Data Call

Eight companies currently underwriting nursing home policies.

Only 13 percent of CA nursing homes covered by admitted insurers.

Average premium per facility $11,553.

Aggregate loss ratio 313 percent for SNF liability insurance.

Follow up was conducted by the CDI to focus on SNFs. In 2000, eight groups or admitted insurers covered SNF liability insurance, insuring 185 facilities or 7,617 beds. The average premium per facility was $11,553, compared to the $9,794 reported for all long-term care facilities. The SNF carriers reported an **aggregate loss ratio** of 313 percent, indicating that over 3 times the amount collected in premiums was expended in claims payments. The average loss per claim was $54,391. For the 185 facilities, 123 claims had been filed during the year. This data only captures the insurance experience for 13 percent of the skilled nursing facilities in the state. The remaining 87 percent are either self-insured, securing liability coverage through arrangements, or insurance companies not licensed in California, or are uninsured.

Rate Increase Trends

Between April 1999 and September 2001, four admitted insurer groups have filed for base premium rate increases in their SNF LTC liability lines. The nature of the requested increases range from 36 percent to 127 percent. The highest rate increase granted by the CDI was approximately 70 percent. The resulting premiums ranged from $170 per bed to approximately $525 per bed. If an insurer does not receive the base rate increase for which it files, the insurer still has the latitude in its premium structure to tighten up its underwriting process, or to not write new or renewal policies.

In addition, two new filings of liability insurance occurred during the same timeframe, by insurers that were not previously offering these liability insurance products in the market. The most recent filing was in September 2001. Of the new market entries, base rates ranged from approximately $650 per bed to $825.

Trend Data From Admitted Insurer

DHS received firm data from one major admitted insurance company, *CNA*, in preparation of this report. *CNA*, one of the largest admitted insurers still providing SNF liability insurance, indicated liability claims experience in California is increasing. In response, *CNA* is increasing its premium rates for 2002 to 2003 by 50 percent to 100 percent. *CNA*'s analysis indicates that over the last three years, the California **claims severity** trend, or the size of the claim, has increased 20 percent. The same measure nationally reflects a 15 percent trend. The **claims frequency** trend, or the number of claims, resides at six percent in California. On a nationwide basis this trend represents four percent.

In setting its premiums for 2002-2003, the insurer evaluated underwriting reports of current accounts, studied account performance for adverse loss experience, as well as other factors including economic and market conditions that may affect premium pricing, and policy terms and conditions. For-profit long-term care facilities that had coverage issued on an occurrence basis in the past will be converted to claims-made policies upon renewal, thereby reducing the insurance company's exposure to risk.

Other Trend Measures

Trend Data from Medicaid (Medi-Cal) Cost Reports

In an effort to gain a more complete picture of the liability insurance experience, OSHPD undertook a study of administration expenses submitted by nursing home providers to estimate expense trends that could be attributable to insurance costs. OSHPD collects data on all SNF facilities from its combined, Medi-Cal cost reports and from OSHPD disclosure forms. These data are the same source used by the DHS Medical Care Services Program to calculate

Medi-Cal rates. The combined "administration" figure is the only data element collected from the facilities that would include the liability insurance figures.

OSHPD reviewed data from 81 facilities that had disclosure reports ending June 30, 2001 and later, which had been filed as of January 15, 2002. From this sample, a median increase of 23 percent was found between 2000 and 2001. This trend may be attributable to liability insurance increases, or upward or downward pressures from other non-identifiable administrative costs. This data may also include varying renewal periods for the insurance policies. With increases occurring, renewals reported earlier in the reporting year may differ from reports later in the reporting year. For these reasons, this information is of limited use.

For SNFs, as with other California businesses, liability insurance is not the only overhead expense that has recently experienced large increases. The price inflation generated by the energy crisis and cost pressures of worker's compensation increases are also affecting the fixed costs facing these facilities.

Affect on Cal-Mortgage Insured Projects

The Cal-Mortgage program requires liability insurance for the long-term care facilities, to which they provide mortgage insurance (unless the parties agree to other terms in writing). Cal-Mortgage is a division of OSHPD that provides credit enhancement for eligible health care facilities, allowing the borrower to secure financing at the State's credit rate. When Cal-Mortgage insures a capital loan, the borrowed funds are guaranteed by the "full faith and credit" of the State of California.

The Cal-Mortgage project managers have been gathering anecdotal stories regarding the challenges some of the facilities are having in maintaining liability insurance. One SNF received a cancellation notice on its policy and it is attempting to procure a new policy. One quote that the facility received would mean an increase in premium from $60,000 to $500,000. An alternative option was to pay $173,000 for a policy with a $100,000 deductible. For this option the facility would still need additional coverage, since it would only be insured for a $1 million claim or $2 million maximum. The public recognizes this facility as an exemplary provider and DHS survey reports affirm this image.

Another nursing home has had liability coverage from The St. Paul Companies, which is eliminating its medical liability coverage. St. Paul quoted a renewal rate, which would mean an increase from $50,000 in 2002, to $273,000 for 2003. The facility has reported that it does not have any prior claims. An alternative insurer quoted a premium rate at $1500 per bed or $640,000. A multilevel nursing home in San Diego noted the problem of compounding increases: 20 percent in 2001, 40 percent in 2002, and a projected 20 percent to 40 percent increase in 2003.

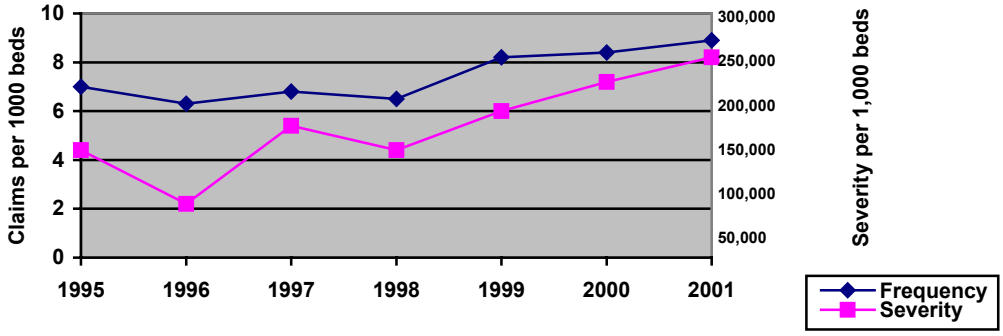
The Cal-Mortgage program is concerned about the burden that the liability rates will have on the facility operations. If an insured facility defaults on its mortgage, the State must take over the obligation.

Trend Data from America Health Care Association (AHCA)

The general trends for the frequency and severity of claims is reinforced by the finding of the Aon actuarial study of long-term care general liability and professional liability. Aon is one of the world's largest insurers, with services in the actuarial and consulting fields. Aon was commissioned by AHCA to evaluate liability rates for long-term care. The report was originally written to evaluate the conditions in Florida, but subsequent studies used California as a focus state and reviewed national trends. According to Aon's findings, the severity or size of the claims in California is trending upward at a higher rate than the frequency of the claims. The participants in this study represent approximately 27,000 occupied beds in California, or 22 percent of all California nursing home beds.[2]

FIGURE 2.

California Annual Number of Claims per 1,000 Occupied Beds /Severity per Claim



Theresa W. Bourdon, Sharon Dubin, "Long Term Care General Liability and Professional Liability Actuarial Analysis," Aon Risk Consultants, Inc. February 28, 2002, pg 28.

Historically, California has experienced higher frequency and severity levels than most other parts of the country.[3] Therefore, the trend line is flatter, yet the claims counts and severity levels are comparatively high.

General Discussions with Insurers

Claims-made vs Occurrence

General discussions with insurers have confirmed a shift to writing long-term care business on a claims-made rather than occurrence basis. "[I]nsurers that stay in the market are moving to a new system that covers the calendar year only—that

is, only claims filed during the calendar year that arose from events that occurred during the same calendar year. Nursing homes have to pay extra for past and future claims—called **"tail" coverage** in the industry—to get full coverage."[4] Traditional insurers start to restrict the occurrence-based policies issued as the environment they are insuring for becomes more volatile or starts to experience a higher number of claims than the insurer had predicted. This change results in a "**shorter tail**" or limits the insurance liability based on the date of claims. Currently, a large number of SNF claims have a **"long tail,"** where claims are being filed two or three years, sometimes more, after the incident took place. With a claims-made block of business, typically an insurer can respond more quickly to a changing risk environment and limit their exposure to legislative changes and to a rapidly changing legal environment. Under the CDI survey, however, the carriers reported that seven of the eight admitted insurers did write business on an occurrence basis in 2001 and did not require a minimum deductible. Updated data are not available for 2002 to demonstrate if this shift in policy form is truly a general trend that can be statistically validated.

Changes in Structure of the Insurance Policy

Other changes insurers reported in the structure of the policies they are now writing include additional deductibles, reduced maximum claims caps, and tightened underwriting criteria. Insurers are also restructuring current policies to eliminate coverage on punitive damages. All of these changes essentially increase the "cost" of liability insurance for nursing homes.

Impact of Lawsuits

"When multiple and/or large claim settlements are made and less than equal premiums collected, negative loss ratios become a focus for an insurance company. An insurer will then ultimately increase premium or elect to dismiss the book of business altogether which will entail canceling or non renewing the existing long term care insureds."

–Mealey's Nursing Home Litigation Conference 2002.

From an insurance perspective, the increased number of lawsuits is problematic, but of greater concern is the escalation of awards associated with the lawsuits and the insurer's inability to predict the settlements or contain the amount of the claims. "It may be easy to dismiss the large and highly publicized awards as aberrations that were later reversed or reduced, as many are. However, many claims are quietly settled in the still-lofty $1 million to $5 million dollar range."[5] The volatility in the market has resulted in the withdrawal of the insurers. Often, the insurers will press for settlement of the lawsuit with the specific intent of containing the claim cost, rather than risking what the jury may award the plaintiff for damages.

The insurers generally agree that the transition in insurance risk has occurred with the passage of elder abuse laws. *CNA* specifically noted that state statutes intended to clarify the rights of long-term care facility residents (the Elder Abuse and Dependent Adult Civil Protection Act, and the Patients' Bill of Rights) and their application in a litigious environment had resulted in escalating defense expenses, settlement awards, and jury verdicts.

GeneralCologne Re conducted a study of 58 voluntarily reported verdicts and settlements for LTC providers and concluded:

> Claim costs are escalating, multimillion dollar verdicts and settlements have replaced the more moderate payments previously associated with personal injuries awards to individuals with a short life expectancy and minimal wage loss. We found at least ten verdicts in excess of $10 million—four were over $50 million—and a long list of settlements at the $1 million mark.[6]

While insurers are unsure how to price a SNF liability product to appropriately ensure the companies' **underwriting profit**, they will either withdraw from the product lines, or limit the coverage, to mitigate the company's exposure to potential losses. The insurance companies have expanded their underwriting process to evaluate the condition of the facilities and the presence of any identifiable risks. *CNA* requests information regarding the structure and focus of the facility's risk management program, if one is in place.

One of the shifts towards limiting risk that the insurance industry is looking for are regulations to tighten the definitions of elder abuse. However, discussions with numerous insurers have also pointed to concerns regarding quality of care in the SNF, especially staffing, as a deterrent to insuring the facilities.

View of Risk for Long-Term Care Provider Types

Hospitals

Insurers view hospitals differently in assessing risk exposure. Some insurers have eliminated their coverage of freestanding SNFs, but continue to cover hospital-based SNFs as a portion of the hospital's overall liability policy, thereby diversifying the risk. Based on an interview with Zurich, a major insurer, which discontinued its coverage of freestanding SNFs three years ago, hospital staff tends to have a higher level of training and hospitals have tended to do better in trial, with fewer and smaller awards. Hospitals typically obtain liability insurance that covers all of their facilities, including the distinct part nursing facility. According to the California Healthcare Association, those who purchase commercial liability insurance are facing renewal premium increases in the range of 30 percent to 50 percent.

Not-for-Profit Facilities

Not-for-profit facilities have tended to have fewer lawsuits, but are also facing increases in premiums. There are some insurers that will write insurance for not-for-profit SNFs only. *CNA* indicated that they would still consider occurrence-based policies for these facilities, but not for-profit facilities. A study conducted by the American Seniors Housing Association indicates that a greater number of non-profit facilities have insurance coverage for punitive damages.[7]

For-Profit Facilities

For-profit facilities have had the poorest claims experience and this trend has led some insurers to differentiate their policies between the for-profit and not-for-profit status of nursing homes. In California, this differentiation is highly significant since over 80 percent of the state's nursing homes are for-profit.

Assisted Living Facilities

Assisted living facilities have also been affected. Insurance companies have begun increasing rates for these facilities, under the belief that similar risk factors exist for assisted living activities as for SNFs. Even though a single facility may not have ever experienced a claim, the insurance company will "pool" the category of coverage, based on location and the type of facility. An actuary will produce analytical projections to measure the risk and weight the exposure of the insurance company to potential claims. These projections can render industrywide increases, without the actual occurrence of increasing claims.

ICF-DD

ICF-DD facilities will assist patients with a higher need for care or for a more specialized type of care than assisted living or residential care facilities. These facilities have recently reported that they are experiencing an increase in their liability premiums.

STATE OF THE LIABILITY INSURANCE MARKET

The proponents for Lloyd's maintain that "the strength of the market comes from shedding the herd nature of the insurance industry."
- HSBC, "Lloyd's Destroying the Myths," January 28, 2000.

What Has Changed Nationally?

Insurance companies in many ways are the purest form of a market-based industry. Losses must be offset by profits. The nature of the insurance industry is to gain predictability and consistency by pooling resources and diversifying risk. Many insurance companies are huge multinational corporations with complex corporate structures, including multiple subsidiary companies, offering specialty lines of insurance or financial products. Historically, nursing homes represented low risk and a good insurance risk. Claims were moderate, but there were limited economic losses.

Perception of LTC Risk

A number of factors within the last few years converged to shift the insurance industry perception of LTC from a "real estate" to a "medical" liability model:

- ***Rising liability losses/change in risk*** – severity and frequency of lawsuits has increased, including the size of jury awards and settlements. Often settlements are structured so an insurer agrees to pay a minimum or maximum amount irrespective of the jury verdict. If the verdict exceeds the maximum, the insurer pays the ceiling—often in the LTC arena, the jury is awarding higher than the settled upon cap. Insurance companies currently view nursing homes as a volatile and high-risk market and therefore, the reinsurers are shying away from the coverage, or are setting their premium rates accordingly.

- ***Increased attention from the media/negative perception of LTC providers*** – numerous features on the LTC industry, largely focusing on occurrences of abuse and neglect, intensifying the public's opinion against the nursing home industry as a whole.

- ***Underpriced premiums*** – The insurers have miscalculated the price of the liability insurance. And during a competitive market period, underpriced premiums allow insurers to compete for market share and allow for additional revenues to be invested in the booming stock market. With the financial downturn in 2001, underpricing is detrimental to the stability of a line of insurance. Insurance companies must maintain a strong financial position to avoid downgrades by the rating agencies (see inset).

Who are the Rating agencies and why are they important?

Organizations competing in the insurance arena have become increasingly complex. Their corporate structures can span geographic borders and incorporate insurance and non-insurance industry segments. Independent ratings are the global standard for assessing the financial strength of insurance companies. Assessing an insurer's ability to honor its long-term commitments is important to distributors, consumers, and financial-market participants around the world. Rating agencies such as A.M. Best, Moody's, and Standard & Poor's provide an objective benchmark and credible financial data to evaluate an insurer's operations and competitive viability.

Rating agencies use a scorecard approach to assign a "grade" to denote the financial strength of an organization. Agencies will also denote an outlook rating to indicate the potential of any anticipated future changes in the rate assignment.

A rating agency defines an organization's success as its ability to respond to a dynamic market, as measured by strong capitalization and operating returns, and a market profile to ensure ongoing viability and financial security. "Insurers that possess a high degree of strategic and operations agility will inevitably return more value to stakeholders and be better positioned to leverage market opportunities."

A.M.Best Company "About Our Ratings."

- ***Record losses for reinsurers –*** Prior to the September 11th terrorist attacks, insurance carriers were experiencing poor underwriting results. The reinsurers—the insurers of the insurance companies—were absorbing the losses that the insurers were experiencing due to the underpricing of the property coverage issued. The reinsurers have dramatically increased premiums to the carriers to cover these losses.

- ***Diminishing equity returns*** – The change in the stock market performance has eliminated a significant subsidy for the insurance market. Therefore insurance companies have more closely reviewed the underwriting performance of the various segments of their portfolio and corrected for shortcomings by premium increases. These pricing corrections have affected automobile insurance, homeowners insurance, and all sectors of liability and medical malpractice insurance.

- ***Events of September 11***– The overall impact of September 11th is still being assessed. It will be noted as the single costliest event in insurance history. The events of September 11 will serve to only speed the **"hardening"** of the market that was already underway. While the losses incurred are being assessed, many reinsurers are freezing their current blocks of business, not writing new business, or in some cases canceling their policies and renegotiating any business they take back. The reinsurers must raise their prices to stay in business.

Cyclical Nature of Insurance

As the industry hardens, insurance companies return to their core businesses and eliminate lines that are volatile or experiencing uncontrolled losses.

The insurance industry, like other industries, is cyclical in nature. While the insurance industry has enjoyed a **"soft"** or expanding market in the past decade, conditions have changed and the market is now hardening, or contracting, as a response to a variety of factors affecting the national insurance industry as a whole, and long-term liability insurance more specifically. The insurance companies are restructuring to minimize losses that have resulted from a myriad of industry factors, few of which have any direct correlation to the nursing home industry. As the industry hardens, insurance companies return to their core businesses and eliminate lines that are volatile or experiencing uncontrolled losses. Currently, insurance companies are shedding lines of medical liability insurance—these are considered to be volatile. These insurance companies will re-adapt to the market conditions and re-position for new opportunities that arise.

As an example, The St. Paul Companies, the largest US underwriter of medical liability and product liability coverage, is exiting the malpractice market. The St. Paul has seen and survived the up and down cycles of the

insurance industry many times over. The company was founded in 1853 and operates worldwide.[8] At the end of 2001,The St. Paul Companies released plans for restructuring to focus on core business lines, shore up reported loses, and reverse the negative outlook of the rating agencies. At the forefront of the restructuring is the exit of the medical malpractice business on a global basis through non-renewal upon policy expiration.[9] In response to the announced changes, A.M. Best affirmed the A+ (Superior) financial strength rating of The St. Paul Companies, Inc. This decision was based on the rating agency's review of the group's initiatives to build a leaner, more focused company.[10]

Even beyond nursing homes, placing liability coverage has been plagued by the up and down cycles of the insurance market. In 1986, Congress passed the Liability Risk Retention Act to help U.S. businesses, professionals, and municipalities obtain liability insurance that had become either unaffordable or unavailable due to the "liability crisis" in the United States. The Liability Risk Retention Act was a marketplace solution, enabling insurance buyers to have greater control of their liability insurance programs. Two entities were created under this federal act, **risk retention groups** and **purchasing groups**. These market options can be utilized by associations or brokers to facilitate additional, customized, insurance products (see Table 3, page 24).

Implications

The market changes affecting the insurance industry are hard to predict and even more difficult to influence. However, the industry is reacting to identified problems in the LTC arena. Concerns about quality of care in the SNFs have caught the attention of the media, with feature stories being run depicting conditions in the nation's SNFs. Congress continues to monitor for improvement in facilities and has taken action to enable states to adopt more stringent elder abuse laws. Within California, the elder abuse laws were intended to encourage lawyers to represent the families of abused or neglected adults. (Welfare and Institutions Code, Section 15600 [j]).

It is difficult for regulators to assess the level of risk facing the nursing home residents because of problems being experienced by facilities in securing reasonable liability insurance coverage. There is no reporting requirement or other mandate that will serve to inform DHS as to the level or existence of liability insurance or as to the status of litigation facing the facilities.

The end goal is to improve the quality of care for seniors and dependent adults. Fear that insufficient care is being provided in nursing homes is the root of increasing insurance rates nationwide. However, the insurance industry response—increased liability insurance rates—is troublesome to both exemplary and poor performing facilities. In crafting a solution, a review of the insurance rates, underlying quality of care, and the legal environment are important in a balanced approach to reform.

Lloyd's of London
A unique insurance market

Lloyd's of London provides a major market resource for liability insurance and reinsurance. Lloyd's has a unique operation and is labeled as specializing in high-risk exchanges. More accurate is that Lloyd's provides specialized insurance coverage and serves as a venue for many surplus and excess line transactions. This article serves to clear up some of the Lloyd's mystique.

The famous Lloyd's of London, considered the birthplace of the insurance market, acts as a barometer to meter the state of the insurance industry. The fact that Lloyd's has registered a loss five out of the last nine years is further evidence of the current challenges facing the insurance industry, and the hardening of the market.

The origins of Lloyd's can be traced back to 1688 and Edward Lloyd's Thames-side coffee shop. Wealthy individuals who frequented the coffeehouse would take shares in policies offered to them in return for a share of the premium. Signing their names one below the other on the policy documents, the participants soon became known as underwriters.

Lloyd's of London is not an insurance company. It is a market, providing a venue of exchange for Underwriting Agencies or Syndicates who compete and co-operate. Lloyd's oversees and regulates the competition. Each Managing Agent of a Syndicate will underwrite business from the brokers and find financial backing to insure the risk. Lloyd's focuses on high-risk, specialty insurance for businesses.

Lloyd's has developed a unique mode of operation—much of which has faced criticism in light of the poor market performance of late. The accounting system for the Lloyd's accounts run on a three-year cycle, as opposed to the standard single year GAAP (Generally Accepted Accounting Principles) accounting standard. Also, Syndicates renew all financing ventures annually, without the long-term ties typical of the insurance industry. There is also a system of unlimited-liability, which exists only on the Lloyd's market, backed not by corporations, but by individuals often known as "Names." The Lloyd Syndicates are minimally invested and Names do not book these results on their operations for the Lloyd's market.

Lloyd's maintains adequate, but lean capitalization—this may not produce the same standard in rating that other, "over" capitalized insurers maintain.[Φ] (Rating agencies favor higher capitalization as a perceived security for the business.) However, A. M. Best still gives the overall Lloyd's market an A (Excellent) rating. Lloyd's underwriting returns are more volatile and tend to lead in and out of cycles more quickly than the insurance market as a whole.

The Lloyd's market can also be accessed for reinsurance, which comprises more than half of Lloyd's total business.

All of these factors have cast a shadow over Lloyd's of London as a highly speculative market arena with only the insider truly being able to decode the state of affairs. The proponents for Lloyd's maintain that the strength of the market comes from shedding the herd nature of the insurance industry and providing a focus on a single underwritten account; allowing for an innovation and entrepreneurship unequalled in the insurance market.

[Φ] HSBC, "Lloyd's, Destroying the Myths," January 28, 2000.

[1] Fine, op. cit., p. 8.
[2] Theresa W. Bourdon, Sharon Dubin, "Long Term Care General Liability and Professional Liability Actuarial Analysis," Aon Risk Consultants, Inc., February 28, 2002, p. 27.
[3] Ibid.
[4] "Without a Net," *Sacramento Business Journal,* February 1, 2002, p. 19.
[5] Allison Schmitz, "Current state of the U.S. Long-Term Care (LTC) market," *Topics,* GeneralCologne RE, 9, p 32.
[6] Ibid. p. 35.
[7] American Seniors Housing Association, "Seniors Housing Liability Report," quoted in "Manage Risks or Kiss Coverage Goodbye," *Eli's Senior Housing Report*, Volume V 2001, p. 166.
[8] The St. Paul, "Fact Sheet," www.stpaul.com/wwwcorporate.
[9] The St. Paul, "The St. Paul announces fourth-quarter actions to improve profitability and business positioning," www.stpaul.com/wwwcorporate.
[10] The St. Paul, "A.M. Best Affirms St. Paul's Financial Strength Rating and Lowers Debt Ratings," www.stpaul.com/wwwcorporate.

TABLE 3.

INSURANCE OPTIONS

	Who Regulates	Who is covered	Financial Obligation	Type of facility
Risk Retention Group (RRG)	Federal law (Title 15, Chapter 65, Sec. 3901). Regulated by the charter state	Once licensed by its state of domicile, an RRG can insure members in all states, as long as the members of an RRG are engaged in business or activities that are similar in regard to the liability exposures created.	This entity operates as an insurance company and therefore retains the risk of the product line and requires the capitalization to establish reserves. RRGs may also be formed to provide reinsurance.	Once the insurance entity is formed, companies of all sizes can be insured. Can be created by a trade organization or professional groups.
Purchasing Group (PG)	Federal law (Title 15, Chapter 65, Sec. 3901). Insurance carriers are regulated by domicile state. May include insurance companies operating on an admitted basis, a surplus lines basis or a risk retention group.	A PG is an insurance purchasing vehicle. The members of the group must have similar liability exposure and the PG can provide customized coverage designed for the members, including risk management programs and credits for low loss experience.	Since the PG is not an insurance entity it does not require capitalization.	Companies of all sizes can be insured. Can be created by a trade organization or professional groups.
Joint Underwriting	California Department of Insurance (CDI) (Insurance Code Section 1853.9 & 1856)	An organization can be formed to allow for joint underwriting or joint reinsurance under the California Insurance Code. CDI requires an organization to file a copy of its constitution; its articles of incorporation, agreement or association; and its by-laws, rules, and governing regulations.	The entity operates as an insurance company and therefore retains the risk of the product line and requires the capitalization to establish reserves.	The incorporated entity.
Specialized Insurance pool	California Department of Corporations Not subject to regulation under the Insurance Code. (Corporations Code Section 5005.1).	California regulations have provisions for insurance pools to be established for two or more health care organizations.	Initial pooled resources of $250,000 are required to establish an insurance pool. Premium payments or other mandatory financial contributions are required of the members to ensure a financially sound risk.	Two or more organizations that are structured to provide or fund health or human services. (Hospitals are not included).

INSURANCE OPTIONS

	Who Regulates	Who is covered	Financial Obligation	Type of facility
Captive Insurance Company	State Department of Insurance In some states, state laws do not allow captive insurance programs to issue insurance policies. In these instances a captive insurance company uses an admitted insurer to front the insurance program.	Most captives act as risk financing vehicles for corporations where the conventional insurance market is unable to provide flexible, stable, and financially attractive terms. A captive insurance company is formed to provide: direct access to the reinsurance markets, coverage tailored to specific needs, accumulation of investment income to help reduce net loss costs, controlled cashflow, incentive for loss control, underwriting and **retention** funding flexibility. Claims may be handled through a third-party administrator or internally, providing the insured greater control of the claims.	This approach is a form of risk financing through which a firm assumes all or a part of its own losses.	A single-owned or pure captive is set up only to handle the risk of a parent company. Group captives are owned by multiple entities. An association captive insurer is owned by members of a sponsoring organization or group, such as a trade association (can be an RRG).
Self-Insured	Self-insurance regulations are promulgated by each of the states and differ from state to state.	Large organizations can reap several benefits from self-insuring. The corporation has the flexibility to raise or lower its retention amount depending on the market pricing for excess insurance. Directly retaining losses increases the internal sensitivity to loss results, and offers the corporation greater control over the claims management process. However, these benefits can quickly disappear if the organization does not have a plan for paying losses when they occur.	A qualified self-insured is usually required to securitize the loss reserves through cash, letters of credit, and/or bonds. The fund auditors will require reserves to be established based on industry rated exposure. The funds that are reserved for potential insurance claims are taken off-balance sheet and show an impact on the company's bottom-line.	Large Corporations, Chains/Systems

INSURANCE OPTIONS

	Who Regulates	Who is covered	Financial Obligation	Type of facility
Self-funding a large deductible	An insured with a deductible program does not have to formalize their self-insurance program with the state.	Under this arrangement, the provider (facility or corporation) secures an insurance policy that has a very large deductible. This allows the provider to self-fund losses up to a certain threshold, after which it has an insurance policy that would take effect.	The insurance carrier will typically require some securitization of the loss reserves.	A single facility or corporation.